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Notes From Cardiology Clinic: When Our Responsibilities Extend Beyond the Patient

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One day in the late 1970's I was called to the Emergency Department to see a patient with chest pain. Although I had only been practicing for a couple of years, I secretly prided myself on my ability to discern cardiac from non-cardiac symptoms. The patient was a gaunt-looking man in his early 60's, with sad, deep-set eyes. He reported retrosternal chest discomfort with physical activity for about 2 years, relieved by rest. The discomfort radiated down his arms, and sounded like typical angina. His symptoms had worsened in the past week due to increasing anxiety, and now were occurring at rest.

His anxiety was related to a pending court date the following week. He was the ex-mayor of a municipality outside of Montreal, and stood accused of fraud and embezzlement. A previous court appearance several months earlier had been postponed because he had been hospitalized with chest pain.

Did he have any objective evidence of coronary disease or myocardial ischemia? His electrocardiogram showed only nonspecific T wave flattening, and an exercise test had been stopped early at a low workload due to fatigue and was thus not informative. I suggested that he should undergo coronary arteriography to determine whether he had coronary disease, how severe it was, and what we could do about it.

"Too dangerous" he replied, and he had a point. The advent of coronary angioplasty lay a couple of years in the future, so the main

purposes of coronary arteriography were for diagnosis and to determine suitability for bypass surgery. In his case a definite diagnosis could lead to earlier incarceration, and bypass surgery was also not a palatable option to him.

Let us stop for a moment and consider how our diagnostic techniques have evolved since that era. Troponin measurements were far in the future. The isoenzymes of creatine kinase had been described[1] but were not yet in widespread use, so that the insensitive and non-specific total creatine kinase was the best measurement to detect myocardial necrosis. Cardiac fluoroscopy was available to detect coronary calcium, but was insensitive and was not widely used. Exercise thallium scintigraphy was in its infancy.

After seeing the patient, I was unsure as to whether he had coronary disease and angina. Was he fabricating his entire story? Was he exaggerating his current symptoms to delay his court appearance? Or was he being totally honest?

I thought about what I would say if called to testify:

“Doctor, does the defendant have heart disease?”

“I don’t know, your honor, he may have blockages in his coronary arteries that are causing his symptoms, but we have no objective evidence of that.”

“Doctor, could an appearance in court be dangerous for him?”

“Your honor, if he does have coronary disease, the anxiety associated with his court appearance could cause a heart attack, or even death.”

Fortunately, the patient had a more credible cardiologist, with gray hair and a dignified manner, who had coincidentally just published the Canadian Cardiovascular Society angina classification.[2] I was spared my day in court, I forgot about this patient, and I cannot even tell you what happened to him.

What Responsibilities Do We Have, Beyond Caring For Our Patients?

In December 2015, Donald Trump’s longstanding personal physician released a statement about the then candidate. He claimed that over the past 39 years, Mr. Trump had experienced “no significant medical problems”, that a recent complete medical examination “showed only positive results”, and that “laboratory test results were astonishingly excellent”. The letter ended with the claim “If elected, Mr. Trump, I can state unequivocally, will be the healthiest individual ever elected to the presidency.”[4] Much later, In May 2018, this physician claimed that Mr. Trump had dictated the letter to him.[4]

Trump’s first physical exam as president followed an eerily similar pattern. His physician, Ronnie Jackson proclaimed: "Some people have just great genes… I told the president that if he had a

healthier diet over the last 20 years, he might live to be 200 years old."[5] Trump subsequently nominated Jackson to become Secretary of Veterans Affairs, but Jackson was forced to withdraw after allegations of misconduct surfaced.[5]

Admittedly, these are extreme examples. And what do these incidents have to do with my patient from years ago? The common thread is the information that we can, or should, release publicly about our patients. Foremost, we cannot release any medical information without our patient's permission. Rare exceptions to this rule include notifying the Department of Motor Vehicles when a patient is no longer fit to drive.

But suppose your patient wants to run for political office, and asks you to release a statement about her health. She asks that you omit mention of the 3 occasions in the past 2 years when she was obliged to seek treatment for paroxysmal atrial fibrillation, and that she is taking an anticoagulant. Should you go along, to help her out? Or should you insist on honesty, and perhaps lose a patient? Since she very well might have future episodes if elected to office, covering up her recent episodes might be shortsighted.

The examples I have used are politicians, but the same issues exist with celebrities, famous athletes, and business leaders. I contend that in these difficult situations, it is crucial that a physician be totally honest. Not necessarily for moral or ethical reasons, but for practical

ones. If you behave like a media lackey, you will be treated like one. If you fudge on a press release, might you not be expected to fudge on a diagnosis or treatment? Honesty is not only best for you, it is best for your patient.

So, simply put, honesty is the best policy. Even if you have to admit to the judge that really, you do not know anything with certainty.

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